

Recommended Core Curriculum Guidelines on Culturally Sensitive and Competent Health Care

Robert C. Like, MD, MS; R. Prasaad Steiner, MD, MPH; Arthur J. Rubel, PhD

Editor's Note: To aid in dissemination of curriculum guidelines created by STFM groups and task forces, *Family Medicine* will begin publishing such guidelines when deemed to be important to the Society's members. The information that follows are recommendations for helping residency programs train family physicians to provide culturally sensitive and competent health care. These guidelines were developed by the STFM task force and groups listed below and have been endorsed by the Society's Board of Directors and the American Academy of Family Physicians. *Family Medicine* encourages other STFM groups and task forces to submit similar documents that can serve as curricular models for residency training and medical education. Groups or task forces that submit information to the journal should follow the Instructions for Authors published each year in the January issue of *Family Medicine* and available on the Internet on STFM's home page (<http://stfm.org>).

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Background

Family physicians and other health professionals care for individuals from a wide variety of backgrounds, both in the United States and abroad. The delivery of high-quality primary health care that is meaningful, acceptable, accessible, effective, and cost-efficient requires a deeper understanding of the sociocultural background of patients, their families, and the environments in which they live. It is also critical to become more aware of how one's own cultural values, assumptions, and beliefs influence the provision

of clinical care and are shaped by social relationships and the contexts in which we work and live.

These are the foundation premises for introducing curricular guidelines for family physicians to promote culturally sensitive and competent health care. An understanding of sociocultural variables in health care settings will facilitate the clinical encounter toward more favorable outcomes and enhance the potential for a more rewarding interpersonal experience. Further, it is assumed that an examination of cultural assumptions of health care delivery systems will provide a better opportunity for quality health care, improved outcomes, better efficiency, and a more cost-effective system of health services and medical care.

This document is an ongoing "work in progress" begun 10 years ago by the STFM Task Force on Cross-cultural Experiences and continued by members of the STFM Group on Multicultural Health Care and Education and the STFM Group on Minority Health Care. The task force had identified

the development of curricular guidelines for culturally sensitive and competent health care as one of its major goals, following the completion of a national survey of family practice residency programs by the task force. The survey results indicated that few training programs provided *any* formal instruction about culture and health.

The curricular guidelines are designed to introduce topics related to culture, health, and illness into residency training and graduate medical education. Family physicians, regardless of their own rearing or the cultural background of their patients, engage in cross-cultural clinical encounters in everyday practice. Competency in recognizing bias, prejudice, and discrimination, using cultural resources, and overcoming cultural barriers to enhance primary care can be learned. These curricular guidelines are designed to make that learning more feasible. The format follows curricular guidelines previously published by the American Academy of Family Physicians.

Although it is common to think

Developed by the Society of Teachers of Family Medicine's Task Force on Cross-cultural Experiences, Group on Multicultural Health Care and Education, and Group on Minority Health Care.

From the Department of Family Medicine, University of Medicine and Dentistry of New Jersey-Robert Wood Johnson Medical School, New Brunswick (Dr Like); Department of Family and Community Medicine, University of Louisville, Louisville, Ky (Dr Steiner); and University of California-Irvine Medical Center, Orange (Dr Rubel).

of "culture" in terms of foreign or exotic situations, these guidelines are intended to prepare family physicians to provide culturally sensitive and competent primary care to patients, families, and communities in the United States. We have attempted to avoid stereotyping groups of people while acknowledging the presence of common attributes. The task force and working groups worked to enlarge the view of culture beyond ethnic differences to include socioeconomic, religious, and functional concerns pertinent to health and health care. The inclusion of culture as a systems variable in family- and community-oriented health care will likely enrich the clinical practice of medicine by providing a broader perspective on the experience of disease, illness, and health. Such a strategy should facilitate a better understanding of various cultural methods for prevention, curing, healing, and caring.

Our groups are aware of the possibility of perpetuating culturally biased or culturally bound notions within these guidelines. Cultural relativism, or relating one's own cultural experiences to those in another setting, requires knowledge about other cultures,

complemented by self-reflection of one's own (often unexamined) cultural values, biases, and subjectivity. The members of the task force and groups worked to become aware of our own medicocentric and ethnocentric biases during the drafting of this document. Recognition of cultural biases and methods to transform them in the context of the therapeutic alliance became one component of these guidelines.

Our focus on culture should not be interpreted to mean that other key issues such as age, gender, race, ethnicity, sexual orientation, social class, or disability are less important for family physicians and other health care providers to understand in terms of their critical impact on clinical practice and health care. We also point out that accepted or preferred descriptive language for describing human phenomena or processes varies across different academic and professional disciplines, is likely to change over time, and can mean different things to different people. The task force and working groups tried to be sensitive to these issues, considered a wide variety of terms, encouraged open debate, actively solicited feedback, and attempted

to reach consensus. We urge the readers and users of this document to be aware of the potential limitations of these guidelines and to be sensitive to the different meanings that specific language may have for both professionals and the lay public.

The task force and working groups recognized a need for clinical relevance and concise, practical guidelines. Themes from anthropology and ethnomedicine are proposed in a practical framework to better enable the person-centered and family-oriented goals of family practice. The training of family physicians who can provide culturally sensitive and competent health care is one small step toward creating a health care system that responds to the needs of individuals, families, and communities in an acceptable, meaningful, and equitable manner. We anticipate that these curricular guidelines will serve as a reference point for future revisions and that the evolving curricular models will benefit all who use them. We also believe that with appropriate modifications, these guidelines can be used as a model by teachers and learners in other medical specialties and health professions disciplines.

ATTITUDES

Residents will develop attitudes that include:

1. Awareness of the impact of sociocultural factors on patients, practitioners, the clinical encounter, and interpersonal relationships
2. Acceptance of the physician's responsibility to understand the cultural dimensions of health and illness as a core clinical task in the care of all patients
3. Willingness to make their own clinical settings more accessible to patients by taking into consideration their residential location, means, and costs of transportation, working hours, language and communication needs, disability status, and other financial and environmental circumstances
4. Appreciation of the heterogeneity that exists within and across cultural groups and the need to avoid overgeneralization and negative stereotyping
5. Recognition of their own personal biases and reactions to persons from different minority, ethnic, and sociocultural backgrounds and the need to deal with cultural countertransference
6. Appreciation of how one's personal cultural values, assumptions, and beliefs influence the clinical care provided
7. Willingness to understand and explicate those values, assumptions, and beliefs and to examine how they affect the care provided to patients that share and do not share a similar perspective
8. Understanding of the limitations of cultural analysis and the role played by other historical, political, economic, technologic, and environmental forces in shaping the delivery of health care to individuals, families, and communities
9. Expressing respect and tolerance for cultural and social class differences and their value in a pluralistic society
10. A moral and ethical obligation to challenge racism, classism, ageism, sexism, homophobia, and other forms of bias, prejudice, and discrimination when they occur in health care settings and society in general

KNOWLEDGE

Residents will develop an understanding of:

1. General Sociocultural Issues Relating to Health Care
 - A. Anthropologic concepts that are essential for the provision of culturally sensitive and competent health care
 - B. How all cultural systems—including those of both patients and physicians—are sources of (congruent and incongruent) beliefs about health, communication about symptoms, and treatment
 - C. The impact of culture on the recognition of symptoms and behaviors related to illness
 - D. How diversity within a culture affects the provision and utilization of care
 - E. How health care systems reflect the prevailing values of the culture(s) in which they exist
 - F. Developmental models of ethnosensitivity (eg, fear, denial, superiority, minimization, relativism, empathy, and integration) in relation to one's own ethnic and sociocultural background

2. Multiculturalism in the United States
 - A. Selected minority, ethnic, and sociocultural groups (according to relevant local needs):
 1. Northern, Western, Southern, and Eastern European-American
 2. Black/African-Americans
 3. Asian/Pacific Island-Americans
 4. Latino/Hispanic-Americans
 5. Native Americans/American Indians/Inuit
 6. West Indian/Caribbean-Americans
 7. Middle and near Eastern-Americans
 - B. Selected vulnerable or "at-risk" groups
 1. Age-specific (infants, children, adolescents, adults, and older adults)
 2. Low income
 3. Homeless persons
 4. Immigrants/refugees
 5. Persons in specific occupations
 6. Migrant workers
 7. Gays and lesbians
 8. Persons with developmental disabilities
 9. Persons with physical disabilities
 10. Persons with mental disabilities
 11. Persons with addiction problems
 12. Persons who are incarcerated
 13. Other special populations
 - C. The changing demographics of various population groups
 1. Historical experiences
 2. Sociocultural characteristics
 3. Economic characteristics
 4. Political characteristics
 5. Geographic characteristics
 6. Religious characteristics
 7. Linguistic characteristics

3. Cultural Perspectives on Medicine and Public Health
 - A. The health-seeking process and illness behavior
 1. Sociocultural determinants of health and wellness
 2. The disease/illness distinction
 3. Personal/familial health and illness-related beliefs, values, attitudes, customs, rituals, and behaviors
 4. Sociocultural risk factors and interventions that can be used to modify these risk factors
 5. Kleinman's "typology of health sectors"
 - a. Use of the "Professional Health Sector" (the organized, regulated, legally sanctioned health professions, such as modern Western biomedicine)
 - b. Use of the "Popular Health Sector" (the lay, nonprofessional, nonspecialist domain of society where ill health is first recognized and defined, and health care activities are initiated)
 - c. Use of the "Folk Health Sector" (nonprofessional, nonbureaucratic forms of healing that are either sacred, secular, or both)
 - d. Interactions within and across the professional, popular, and folk sectors of care
 - e. Outcomes of professional, popular, and folk healing
 6. Access issues and barriers/facilitators to care
 - B. Cultural assumptions and their influence on the US health care system
 1. Basic value orientations (in relation to human nature, other people, activity, time, and the environment)
 2. Self-help/volunteerism/consumerism
 3. Advocacy/activism
 4. Populism/elitism
 5. Separatism/pluralism/integration
 6. Opportunity/optimism
 7. Efficacy/effectiveness/equity
 8. Prejudice/discrimination (eg, racism, classism, ageism, sexism, homophobia)
 9. Privilege/disadvantage
 10. Power/powerlessness/critical consciousness

4. The Ethnosensitive (Cultural) Epidemiology of Health and Illness Problems of Diverse Population Groups
 - A. Clinical problems relating to the nation's health promotion and disease prevention objectives
 - B. Clinical problems having high mortality and morbidity rates
 - C. Clinical problems relating to the stage of the individual and family life cycles and major life events (pregnancy, birth, marriage, death, etc)
 - D. Clinical problems that are linked to culture shock from migration, intergenerational value orientation conflicts, and acculturation/assimilation processes
 - E. Clinical problems relating to "folk illnesses" (eg, "high blood," "falling out," "evil eye," "susto," "ghost sickness," "koro")
 - F. Clinical problems present in country or geographic area of origin

SKILLS

Residents will develop skills in the following areas:

1. Clinical Practice
 - A. Forming and maintaining a therapeutic alliance
 - B. Recognizing and appropriately responding to verbal and nonverbal communication
 - C. Constructing a medical and psychosocial history and performing a physical examination in a culturally sensitive fashion
 - D. Using the biopsychosocial model in disease prevention/health promotion, the interpretation of clinical signs and symptoms, and illness-related problem solving
 - E. Prescribing treatment in a culturally sensitive manner
 - F. Using the negotiated approach to clinical care
 1. Berlin and Fowke's LEARN model
 - (L)—Listening to the patient's perspective
 - (E)—Explaining and sharing one's own perspective
 - (A)—Acknowledging differences and similarities between these two perspectives
 - (R)—Recommending a treatment plan
 - (N)—Negotiating a mutually agreed-on treatment plan
 2. Explanatory model (EM) elicitation techniques
Eliciting individual or family EMs: (ie, "ideas about the etiology, onset, pathophysiology, prognosis, and treatment of disease and illness")
 3. Illness prototype (IP) and patient request (PR) elicitation techniques
Eliciting individual or family IPs: (ie, "ideas about sickness based on previous personal experiences, the experiences of significant others, or media-transmitted information")

Eliciting individual or family PRs: (ie, "the type of help [clinical resource] the patient would like [hopes, wishes, wants] to receive from the practitioner")
 4. Pfifferling's cultural status exam
 5. Stuart and Lieberman's BATHE model—*Background/Affect/Trouble/Handling/Empathy*
Exploring the psychosocial context of the patient's visit to provide social support and as a basis for gaining insight
 - G. Using family members, community gatekeepers, translators/interpreters, and other community resources and advocacy groups
 - H. Working collaboratively with other health care professionals in a culturally sensitive and competent manner
 - I. Working with alternative/complementary medicine practitioners and/or indigenous, lay, or folk healers when professionally, ethically, and legally appropriate
 - J. Identifying how one's cultural values, assumptions, and beliefs affect patient care and clinical decision making
2. Administrative Practice
 - A. Analyzing the sociocultural dimensions of one's own practice site and the implications for practice management
 - B. Implementing a cultural sensitization training program for office/clinic staff
 - C. Promoting cultural competence in health care organizations as part of total quality management and continuous quality improvement activities
 - D. Using ethnographic and epidemiological techniques in developing a community-oriented family practice
 - E. Influencing the cultures of health care organizations and professional groups (eg, managed care organizations, ambulatory care facilities, hospitals, nursing homes, specialty societies)

Implementation

The implementation of this core curriculum should be longitudinal. For family practice residency training programs, the learning experiences should be offered throughout the 3 years of residency training. For medical students, positioning portions of the curricula into required courses and into electives should extend over the preclinical and clinical years.

Culturally sensitive and competent health care should be integrated into existing educational clinical activities, including hospital attending rounds, morning report, grand rounds, lecture series, clinical case conferences, morbidity and mortality rounds, small group seminars, Balint groups, precepting, videotape reviews, journal club, home visits, community fieldwork experiences, and self-learning. Block elective experiences are also desirable, which involve work with specific minority, ethnic, or cultural groups, folk or lay medical practitioners, or placements in cross-cultural/international settings.

Residency faculty should function as role models by conducting their personal and professional affairs to reinforce the concept of culturally responsive health care. Ongoing faculty development activities are strongly recommended to deal with potential areas of discomfort and resistance and to identify attitudes, knowledge, and skills that need to be further improved or strengthened. Locally available behavioral and social scientists who have expertise in clinically applied anthropology should be identified, and interdisciplinary collaborative work with them is highly recommended. Linkages should also be sought with formal and informal community leaders, advocacy groups, culture brokers, and appropriate alternative/complementary medicine practitioners and/or indigenous

healers. Specific intercultural training strategies include: cognitive training, behavior modification, experiential learning, cultural self-awareness, and attribution training. Relevant bibliographic, games/simulations, and audiovisual materials should be available in the residency library (see attached listing for some selected examples). Implementation strategies will likely vary across residency programs and should be individualized to cover issues relating to the sociocultural groups in need of and receiving health care in local communities. Faculty and resident interests, existing resources, and available curricular time will also be important determinants of the planned intercultural training activities.

Systematic quantitative and qualitative evaluations of the impact of these educational programs need to be carefully designed and carried out and the results shared with interested audiences. In particular, it will be important to learn from how various people have implemented the guidelines and the programmatic challenges experienced from both successful and unsuccessful efforts. We would propose that after a specified period of time (eg, 5 years), STFM should gather feedback and conduct a review of these guidelines and related educational activities. This could be done through a cooperative effort involving interested groups, task forces, and other networks existing in STFM.

RECOMMENDED CROSS-CULTURAL HEALTH CARE RESOURCES

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EXPERIENTIAL EXERCISES/GAMES/ SIMULATIONS/VIDEOS

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Corresponding Author: Address correspondence to Dr Like, University of Medicine & Dentistry of New Jersey-Robert Wood Johnson Medical School, Department of Family Medicine, One Robert Wood Johnson Place, CN 19, New Brunswick, NJ 08903-0019.

LIST OF CONTRIBUTORS

In alphabetical order

- Jeffrey Borkan, MD, PhD
University of Massachusetts
and Ben-Gurion University of the Negev, Israel
- Kathleen Culhane-Pera, MD, MA
St Paul-Ramsey Medical Ctr., St Paul, Minn
- Celestine M. Fulchon, PhD
Montefiore Medical Center, Bronx, NY
- Roberta E. Goldman, PhD
Brown University
- Cynthia Haq, MD
University of Wisconsin
- Cecil G. Helman, MD
University College London, England
- Thomas M. Johnson, PhD
University of Alabama, Huntsville
- Martin L. Kabongo, MD, PhD
Sharp Family Practice Residency Program
La Mesa, Calif
- Robert C. Like, MD, MS
UMDNJ-Robert Wood Johnson
Medical School
- Ramoncita R. Maestas, MD
Providence FP Residency Program, Seattle
- Arthur J. Rubel, PhD
University of California, Irvine
- George W. Saba, PhD
University of California, San Francisco
- Linda M. Sinapi, MSW, CISW
University of Connecticut
- Howard F. Stein, PhD
University of Oklahoma
- R. Prasaad Steiner, MD, MPH
University of Louisville
- Laura A. Williams, MD
UMDNJ-Robert Wood Johnson
Medical School